DOCUMENT RESUME

ED 457 495 CG 031 278

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TITLE Second Year Evaluation Report: Family to Family Program.
PUB DATE 1999-03-00
NOTE 12p.
PUB TYPE Reports - Evaluative (142)
EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Attitude Measures; Children; *Community Health Services; *Emotional Disturbances; Family Programs; Health Personnel; *Mental Health Programs; *Parent Attitudes; *Program Evaluation; *Respite Care; Social Services

ABSTRACT

This evaluation report of the Family to Family Program assesses parental attitudes towards their Family to Family experience and the functioning of their emotionally impaired children. Topics include administration and administrative support; recruitment of consumer families; identification of host families; consumer support services; and consumer family characteristics. This evaluation assesses the following variables: (1) the functioning of participating children, (2) family cohesion and adaptability, and (3) parental attitudes about personal and family issues which the program is designed to assist through a replacement questionnaire. The three major activities of identifying suitable consumers, locating appropriate host families, and providing initial and ongoing services to consumers, their families, and host families were all found to be satisfactory. Program performance during this evaluation period was positive, with near full enrollment, reasonable ancillary services to host and consumer families, and organizational support consistent with the needs of the program. Data in the future will be able to measure effects of the program on the consumer and their families in terms of individual and family functioning. (JDM)

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SECOND YEAR EVALUATION REPORT

FAMILY TO FAMILY PROGRAM

March 1999

Luellen Ramey, Ph.D and David P. Meyer, Ph.D.

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Family to Family Program
Second Year Evaluation Report
March, 1999

Introduction and Scope of Report

This evaluation report covers the period from February, 1998 until March, 1999. Topics include administration and administrative support, recruitment of consumer families, identification of host families, consumer support services and consumer/ consumer family characteristics. Individual children served by the program will be described based on clinicians' ratings on the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, 1990). Consumer families will be described using the Preplacement Questionnaire and the Family Cohesion and Adaptability Scale II (FACES II) (Olson, Portner and Bell, 1982). This report will therefore assess all four of the variables proposed in the Evaluation Plan. These variables and the means of assessment are:

1) Functioning of participating children. (CAFAS)
2) Family cohesion. (FACES II)
3) Family adaptability. (FACES II)
4) Parental attitudes about personal and family issues which the program is designed to ameliorate. (Preplacement Quesionaire)

Data are available for virtually all enrolled families and children at the time of enrollment. The Evaluation Plan calls for the same instruments to be administered post treatment as well. A minimum treatment of six months has been agreed upon for all children in the program for evaluation purposes. Pre-post data collection will be carried out when cases of at least six months program duration are closed and for all cases of six months duration or more at the end of the third year of program operation. The pre-post data analysis will be described in the third year Evaluation Report. Thus far no closed case has attained the six months patricipation standard. In addition to consumer and consumer family variables, this report will evaluate activities necessary to carry out the intent of the program.

Principle Program Actvities

The Family to Family Program seeks to provide respite care for 25 families with emotionally impaired children through regular out of home care with host families. This is intended to keep consumer families intact. and to improve family functioning and quality of life. Thus the Family to Family Program engages in three major activities:

1) Identifying and enrolling appropriate consumer families;
2) Recruiting suitable host families and arranging the respite care;
3) Providing ongoing support to both consumer and host families.

This report will evaluate the program in terms of those activities over the past year, as well as the level of administrative support on the part of the Oakland County Community Mental Health Authority.

Administrative Support

It is apparent to the evaluators from their contacts with program staff that the Oakland County Community Mental Health Authority has provide appropriate training, supervisory and physical support for the Family to Family Program. The original Family to Family Program Coordinator, Christine Miller left the position and has been replaced by Terry Clisshold who has carried out the work of Program Coordinator in a diligent and professional manner. Her supervisor, Michelle Quarton, oriented and trained Ms. Clisshold, providing a relatively seamless transition from one coordinator to the other. The Program Coordinator is responsible for the day to day operation of the program, carrying out numerous activities to encourage clinicians to refer appropriate consumers to the program, to locate and negotiate with host families, to assist enrolled families with various problems, to provide informational and educational support for consumer and host families, and to carry out administrative and recording functions. For all of this, Michelle Quarton has offered a knowledgeable, resourceful and accessible supervisory framework. The evaluators have been impressed with Ms. Quarton's casework expertise and clinical acumen. As for the prosaic aspects of providing for the Family to Family program: technical, secretarial, space, supplies and other material resources all seem adequate to the needs of the operation.

Recruitment of Suitable Consumer Families

The foreseen capacity of the Family to Family Program was 25 families with emotionally impaired children. At present, about 20 months since the first enrollments. in June, 1998, there are 21 families and 22 children enrolled in the program, a better approximation of designed capacity. This represents a significant improvement over a year ago, when just 14 families and 14 children were enrolled. The total number of enrollments since program inception is 33. Of those terminated from the program, the most common reason is moving from the area (6); others have terminated as unsuitable for the program (2), placement in foster care or restrictive environment (2). and giving up parental rights (1).

With enrollments at 84% of program capacity, it does not appear that numbers constitute a serious problem. Nevertheless, the program must continue aggressive recruitment efforts in order to reach the goal of 25 active families. As noted in last year's report, the vast majority of referrals are from the southern area. Increased cooperation from northern area clinicians should be a priority in the coming year. The Program Coordinator reports high receptivity and a number of referrals to the program on the part of new clinicians, a hopeful trend. Overall, in consideration of the suitability and numbers of referrals to the Family to Family Program, the recruitment activity is evaluated as satisfactory.

Host Family Matching

This is the most vexing aspect of the Family to Family Program, and of respite programs in general. Ideally, the host family not only provides its primary function of time off for the parents, but also, a relatively healthy environment for the child, and some modeling for the family of origin. In this manner , previous unhealthy patterns of interaction may be improved. In the real world such respite placements are difficult to come by, and in the case of this program, with its high incidence of children with impulsive, hyperactive and aggressive disorders, even more difficult to find than usual. The plain fact is that many of the children for whose parents respite is sought, are somewhat unappealing to host families. This kind of respite care requires not just dedication, but skill in dealing with emotionally impaired and typically, behaviorally troublesome children. A certain amount of staff time must be devoted to host family orientation, training and problem solving. In a few cases, the match between families did not work out and a second host family had to be found. Currently all 22 active cases have host families which are deemed suitable. The matching of host families, especially considering the difficult clientelle, is evaluated as satisfactory.

Providing Ongoing Support for Consumer and Host Families

A number of strategies have been employed with respect to orienting, educating, supporting and intervening as necessary with consumer and host families. Regular group meetings were held during the first year of operation, but poor attendance due to families' competing activities forced the staff to reconsider the feasibility and cost effectiveness of these meetings. During the second year, telephone, mail, and where possible, e-mail contacts have proven sufficient to keep the Family to Family staff in touch with the consumer and host families. The newsletter, which had not been sent out in over six months is now in preparation for Spring, 1999 mailing. Home visits, which are very costly, have generally not been undertaken nor seen as necessary. From all this, it appears that a realistic and sufficient level of support is being accorded to consumer and host families in the program, and therefore this function is evaluated as satisfactory.

Consumer Demographics

Consumers have ranged in age from 5 to 17 with a mean of all enrolled since program inception of 10 yrs. 5 mos. The 14 consumers enrolled during the past year ranged from 7 yrs. 2 mos. to 14 yrs. 7 mos. with a mean age of 10 yrs. 3 mos. Of these 8 were males and 6 were females. The current enrollment is divided into 15 males and 7 females. One family, it should be noted, has two children in the program.

CAFAS Measurements

The CAFAS yields 4 scores (0 = no/minimal impairement; 10 = mild impairement; 20 = moderate impairement and 30 = severe impairement) on five scales listed below.

1. Role performance - subscales are school/work, home and community.
2. Behavior toward others.
3. Moods/self harm - subscales are moods/emotions and self harmful behavior
4. Substance abuse
5. Thinking

Where there are subscales, the highest of the scores is used. The 5 Scales are summed to yield a Total Youth Score ranging from 0 to 150. Clinical indicators for Total Youth Scores are:

10 = may benefit from some intervention or prevention.

20-30 = treatment on an outpatient basis assuming no risk factors (suicide, self or other harmful due to aggression, sexual behavior or firesetting, or psychotic/organic symptoms with severe incapacitation.

40-60 = may need services beyond weekly outpatient visits, but not likely residential treatment.

70-80 = may need intensive therapeutic program, depending on resources and risk factors.

90 or higher = restrictive/supervised living situation may be needed.

The Family to Family Program appears most suitable for children of moderate CAFAS Total Youth Scores, though those with more severe dysfunction might also benefit with additional supportive services. In fact we do find a wide range of Total Youth Scores: from 30 to 110. The overall mean Total Youth Score of current consumers in the program is 66.5, indicating a midrange level of impairment and a need for services beyond weekly outpatient care. Among the Family to Family Program consumers, 6 have CAFAS Totals of 90 or more, indicating a need for careful monitoring and high level supportive services. Case notes indicate that all these cases are working out with the host families. Mean CAFAS scores of current consumers on the five scales along with numbers of consumers falling into the three impairment levels are summarized in Table 1. CAFAS scores were available for 20 of the 22 currently enrolled children.

Scales	Mean Scores	Impairment Levels # Severe	# Moderate	# Minimal
Role Performance	24.0	11	6	3
Behavior toward Others	18.0	4	9	7
Moods/ Self Harm	18.0 (Moods = 16.5)	5	7	8
Substance Abuse	0	0	0	0
Thinking	6.5	2	1	17

Table 1: CAFAS Consumer Scores (n = 20)

Of the 20 cases for which records were available, 9 had scores of 70 or higher, 9 had scores of 40 to 60, and 2 had scores of 30 or less. As table 1 indicates, Role Performance was the most common severe impairement and had the highest mean score; Behavior toward Others was next in mean score and had the largest number of moderate impairments; Moods were also a common problem. Self Harm, Thinking and Substance Abuse were uncommon to non-existent in this sample.

Risk Factors were evaluated in 9 of the cases; of these, 7 were for aggression, and 2 for self harm. The number of aggressive risks is supported by DSM IV diagnoses of oppositional defiant disorder in 3 cases and attention-deficit/ hyperactivity disorder in 12 cases (some with ODD). No other DSM IV diagnosis appeared more than once.

The two optional scales, Caregiver Resources: Material Needs, and Family/ Social Support were rated in 18 cases. Table 2 summarizes these ratings of the primary caregivers.

Impairment levels	Caregiver Support: Material	Family/Social
0 - None	8	3
10 - Mild	7	5
20 - Moderate	3	9
30 - Severe	0	1
Mean Caregiver Support Level:	7.2	14.4

Table 2: CAFAS Caregiver Support Ratings (n=18)

As is clear from Table 2, this group of families does much better at providing for their children's physical needs than their social and emotional needs, and providing a home setting free from such risks as abuse or parental alcoholism. It is noteworthy that only one family was rated as having severe impairment in either category. The mean rating indicates problems in the social support area from mild to moderate, so that staff monitoring of the consumer family situation is in order. These support ratings are similar to last year's, when means for material and social support were 5.0 and 13.9.

Measures of Family Cohesion and Adaptability: the FACES II

The Family Adaptability and Cohesion Scales have been developed over the past two decades by D. H. Olson and colleagues of the Family Inventories Project at the University of Minnesota. These instruments are based on the Circumplex Model of family functioning (Olson, 1983). While a full discussion of the model is outside the scope of this report, a brief explanation is offered. The Circumplex Model posits three dimensions of family functioning:

- cohesion: the degree to which members are connected to/ separated from the family.
- adaptability: the extent to which the family is able to change and be flexible.
- communication: this dimension facilitates movement in cohesion and adaptability.

The Circumplex Model and the scoring of FACES instruments result in 4 levels of cohesion (disengaged, separated, connected and enmeshed), and 4 levels of adaptability (rigid, structured, flexible and chaotic). The combination of these 4 levels with each other produces 16 family types. Figure 1 illustrates these types and the threefold clinical evaluation associated with them-- balanced, midrange and extreme.

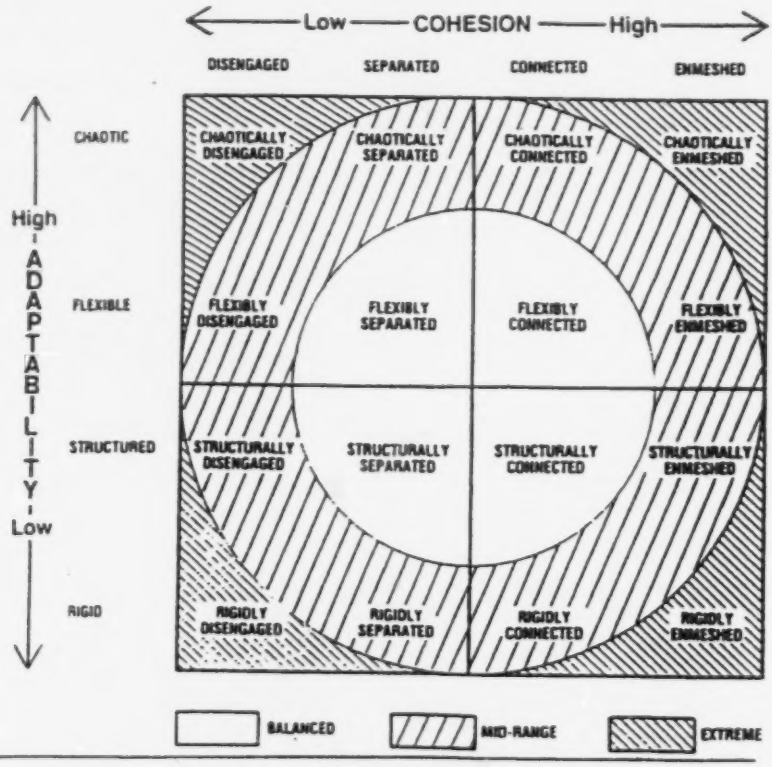

FIGURE 1. CIRCUMPLEX MODEL: SIXTEEN TYPES OF MARITAL AND FAMILY SYSTEMS

Healthier types in Figure 1 are in the center; the least healthy are at the corners. Therapeutic intervention is designed to move the family by means of improved communication toward the more central types shown in white.

The FACES II version was selected from those available due to its stronger alpha reliability, concurrent validity and large national norming sample of over 1000 families, 400 of which had adolescent children. FACES II alpha reliability (a particularly desirable type of reliability computation, see Gregory, 1996,) was found to be a robust .87 for the Cohesion Scale, and an acceptable .78 for the Adaptability Scale, with a Total Scale coefficient alpha of .90, also robust. The validity of the FACES II is supported by concurrent studies, comparing it to other instruments which measure similar constructs. A typical study compared the FACES II to the Dallas Self Report Family Inventory and reported a correllation of .93 on the Cohesion Scale , and .79 on the Adaptability Scale. Both correlations exceed the .01 level of confidence (Hampson,R.B., Hulgus, Y.F. and Beavers,W.R.,1991) .

The Circumplex Model described above has been modified as a "3 Dimensional Model " (Olson, 1991) in which linear scoring is employed. This methodology and modest reconceptualization is shown in Figure 2. The enmeshment dimension is replaced with "very connected " on the Cohesion Scale and the chaos dimension is replaced with "very flexible" on the Adaptability Scale. Thus in this scheme of things, higher scores indicate better functioning. This is in recognition of the fact that the FACES II does not capture the extremely high categories of "enmeshment" and "chaos".

Cohesion

The mean score of the national sample on the Cohesion Scale was 64.9 with a standard deviation of 8.4. The mean of the Family to Family Program families was 51.7, which falls at the 6th percentile. This indicates a generally low level of functioning as a group. Only one of 20 families for whom FACES II scores were available, scored in the "Very Connected" category; eleven fell into the lowest "Disengaged" category; six families were rated "Separated" and three were "Connected".

Adaptability

The mean score on the Adaptability Scale for the national norming group was 49.9 with a standard deviation of 6.6. The Family to Family group averaged 37.7, which places them at the 3rd percentile, even relatively below their performance on the Cohesion Scale, and strongly indicative of family disfunction in this area. None of these families scored in the "Very Flexible" category, while ten families fell into the lowest "Rigid" rating. Six families were scored "Structured" and four fell into the "Flexible"range.

Combined Scores

Cohesion and adaptability scores may be combined to form 16 types from the most dysfunctional "Disengaged rigid", to the most functional "Very connected very flexible", as seen in Figure 2 below. The numbers of each type of family in the Family to Family Program from least to most functional are:

- Disengaged rigid = 7
- Separated rigid= 3
- Disengaged structured = 3
- Separated structured = 2
- Disengaged flexible = 1
- Connected structured = 1
- Separated flexible = 1
- Connected flexible = 1
- Very connected flexible = 1

These types can be evaluated as "extreme" (disengaged/ rigid), "mid-range" (separated /structured), "moderately balanced" (connected/ flexible), or "balanced" (very connected/ very flexible), by averaging the cohesion and adaptability scores. By this scoring, we find 11 "extreme" types, 7 "mid-range" types, no "moderately balanced" types, and 2 "balanced types" among the Consumer families. Figure 2 below depicts the linear scoring system and interpretation.

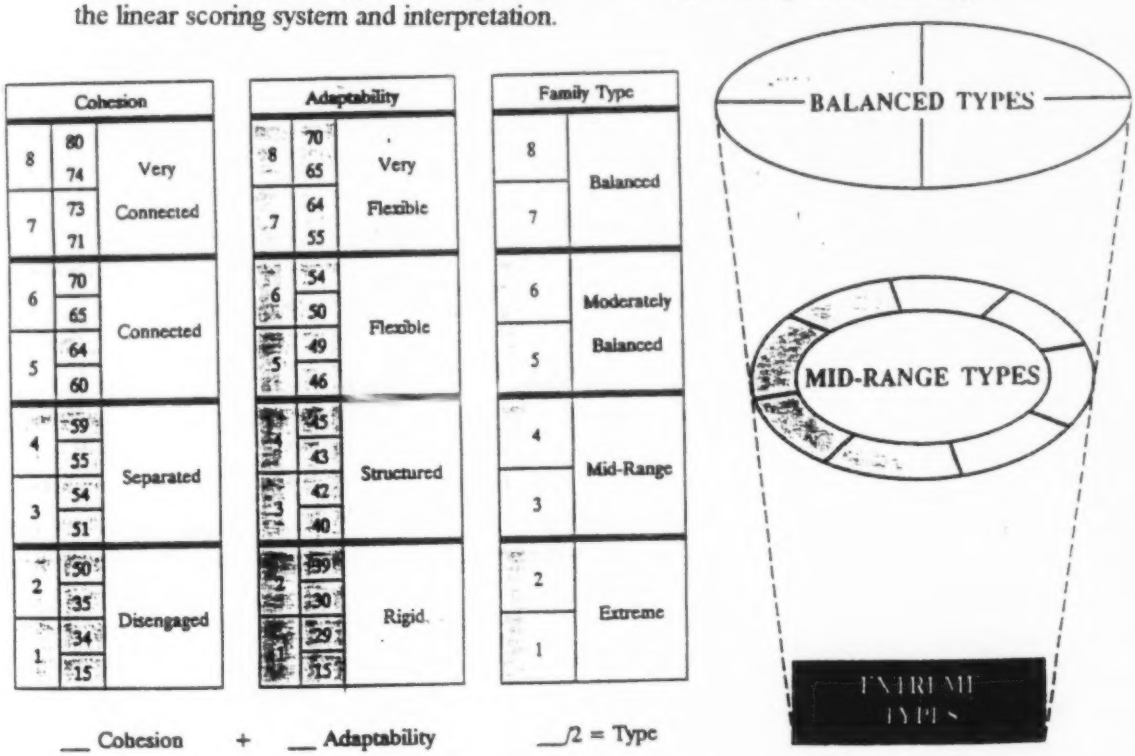

Figure 2. FACES II: Linear Scoring & Interpretation

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Preplacement Questionnaire

This non- standardized instrument is a 10 item, 4 point Likert type scale designed to examine the following factors:

- ability to maintain the child at home (Q #1)
- stress level for self (Q #2) and family (Q #3)
- time available for self (Q #4), other children (Q# 5), spouse (Q #6) and friends (Q# 7).
- ease of childcare arrangements (Q#8)
- sense of control over one's life (Q# 9)
- adequacy of outside support (Q# 10)

Scores below 2.5 indicate a lack of problems in the various areas of inquiry, and those above indicate their presence. The range of scores for the consumer families ranged from 1.55 to 4.0, with a mean of 3.04. Three families scored below 2.5, and 13 scored 3.0 or higher, indicative of the pervasive presence of difficulties among them. When the scores are analyzed by question, the rank order of problem areas are:

- having time for self (mn. = 3.74)
- having time for friends (mn. = 3.5)
- having time for spouse (mn. = 3.47)
- ease of childcare arrangements (mn. = 3.4)
- having time for other children (mn. = 3.26)
- adequacy of outside support (mn. = 3.03)
- sense of control over one's life (mn. = 2.93)
- stress level for self (mn. = 2.76
- stress level for family (mn. = 2.74)
- ability to maintain the child at home (mn. =2.08)

Lack of time for self, friends, spouse and other children are clearly serious problems with this group of families, and consistent with the need for respite. Despite the rating of all other areas as problematic, these families do believe in their ability to maintain their children at home.

Summary and Recommendations

In terms of program support we find that the Oakland County Community Mental Health Authority has provided suitable physical, personnel, and supervisory conditions for the Family to Family Program. The three major activities of identifying suitable consumers, locating appropriate host families and providing initial and ongoing services to consumers, their families and host families have all been found satisfactory. This represents an improvement over last year as far as identifying consumers is concerned and though the current enrollment of 22 consumers is considered satisfactory, we do recommend that continued efforts be made to reach the proposed level of 25 consumers. We find the fact that suitable host families have been found for all consumers especially commendatory and indicative of staff diligence. Orientation and support for consumers, their families and host families has also been carried out in

a timely and sufficient manner to meet their needs and maintain them in the program.

We have reviewed a wide range of data, including case notes, CAFAS scores, a standardized family functioning measure, the FACES II, and a questionnaire designed to explore issues connected to the goals of the program in order to gain as complete a picture of the consumers and their families participating in the program. What emerges from these data is a picture of a consumer group which suffers moderate to severe dysfunction, especially in the areas of role performance at home and school, aggressive behavior toward others, and mood disorders. The consumer families are revealed as troubled, with few exceptions, tending toward disengagement and rigidity in family interaction. Parents of consumers indicated that they suffered from insufficient time for themselves, spouses and their children, problems with childcare and a lack of supprt. These are all indicators of appropriateness for respite assistance.

Overall we view the program performance over the past year in a positive light. with near full enrollment of appropriate consumers, timely and reasonable ancillary services to host and consumer families and organizational supports consistent with the needs of the program. Next year, when post data are available we expect to be able to measure the effects of the program on consumers and their families in terms of individual and family functioning.

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